The University of Toledo Medical Center
Health Information Management
Release of Information Unit
1015 Research Drive, Toledo, OH, 43614
Phone: 419-383-4982 Fax: 419-383-3001

Authorization to Release Copies of a Medical Record

Please complete this form in its entirety so we can help you receive the information you are requesting.

Patient Name:_____ Date of Birth:_____

Street Address:_____ Medical Record Number:_____

City/State/Zip:_____ Phone:_____

e-mail Address:_____ Fax:_____

☐ Send to ☐ Send from company/Organization:_____

Street Address:_____

City/State/Zip:_____ Phone:_____

e-mail:_____ Fax:_____

Purpose of release/disclosure to other person/organization:

☐ Continuity of Care ☐ Request of Patient ☐ Other (specify):_____

☐ Outpatient Surgery, Date of Service:_____ ☐ Clinic or Office Visit, Date of Service_____

☐ Inpatient Admission, Date of Service:_____ ☐ Emergency Department Visit, Date of Service_____

Information to be released: (check all that apply)

☐ Discharge Summary ☐ Emergency Department Reports ☐ Radiology/Ultrasound Reports ☐ Billing

☐ History & Physical ☐ Physician Progress Notes ☐ Laboratory Reports ☐ Complete Set of Medical Records

☐ Operative Reports ☐ Psychiatric Health Record ☐ Other:_____

☐ Alcohol & Drug Detox/Treatment, specifically:_____

_____

How much/what kind of information; explicit description of substance use disorder information that may be disclosed

Information to be: ☐ Electronic Delivery (see instructions on back) ☐ Pick Up ☐ CD ☐ Paper copy ☐ Mailed

1. I hereby authorize The University of Toledo Medical Center (UTMC), its agents and its employees to release Protected Health Information about me/my child to the recipient which may include tests results, diagnosis, treatment or other information about HIV or other communicable disease, if any, alcohol and drug information protected by Federal Regulation (42CFR Part 2), if any, and mental health information if any.
2. I am the patient, or the legally authorized representative of the patient, listed above. I request The University of Toledo Medical Center to release my protected health information (or the patients information listed above to:
3. This authorization may be revoked in writing by sending to the address at the top of this form, at any time, except to the extent that action has been taking in reliance on this authorization. Unless otherwise revoked this authorization is valid for 60 days or date/condition/event:_____
4. I hereby waive and release the facility, its employees and attending physicians from legal responsibility or liability from the release of the above information in accordance with this authorization.
5. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by our hospital's policies and applicable law unless re-disclosure specifically prohibited by law.
6. UTMC may not condition my treatment or payment on my signing this document.
7. I have been informed that UTMC utilizes an outside contracted copy service. I have been informed that copies of my medical record(s) are subject to a copying fee, Pleases see second page regarding our fee schedule.
8. A photocopy is as valid as the original

_____ _____ _____
Patient or Person Authorized to Consent Date Time

_____ _____
Patient Signature Relationship to Patient

Notice to Recipient: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Office Use Only ID Verified: ☐ Yes ☐ No Date Received:_____ Date Processed:_____

Information: ☐ Mailed ☐ Picked Up ☐ Faxed Processed By: ☐ HIM Staff ☐ Other:_____

R O I

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REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON
If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include. Letters of Representation, Guardianship papers, Affidavits of Heir at Law, etc. Please contact the Release of Information Unit at (419) 383-4982 to determine the documentation that will be required to process your request.

SUBMITTING REQUESTS & RECEIVING RECORD COPIES
Patient authorizations need to be submitted for release of protected patient health information. Requests for medical records generally take 7 to 10 working days to process. A completed authorization needs to be signed and dated by the patient or legal guardian.

For request for continuing medical care, the following will be sent:
Office Progress Notes
Discharge Summary
Emergency Report
History and Physical
Operative Report
Results of any diagnostic reports (i.e.: x-ray, MRI, labs, EKG, etc.)
There is no charge for records released to your physician for continuing medical care

ELECTRONIC DELIVERY OF YOUR MEDICAL RECORDS
Fax your signed copy to 419-383-3001. Once enabled, you will receive two (2) e-mails. The first e-mail contains the invoice number, and the second e-mail contains a Personal Identification Number (PIN). These e-mails will provide instructions on how to access records on the eDelivery website.

Request for Personal Use:
Charges apply:

If the record is delivered in paper	$ 0.05 Per Page for supplies (paper and toner) Plus $ 0.90 flat labor fee Plus actual Postage and tax
If the record is delivered electronically	Reproduction Fee $ 6.50 Plus tax
Radiology images on CD	$05.00 (charge by Radiology Department)

Request from Insurance and for Attorney's (without patient directive)

There will be a charge for copies of medical records, when patients authorize release of such information to insurance companies, attorney/law offices, etc.

Base Fee - $20.68	
Pages 1-10	$ 1.36 per page
Pages 11-50	$ 0.70 per page
Page 51 and higher	$ 0.28 per page
Plus actual Postage	

Patient will not be responsible fo4r these charges. The requestors will receive an invoice for CIOX Health.

The Release of Information office is located at
1015 Research Drive
Toledo, OH 43614
Phone: 419-383-4982
Office hours; 8:30 to 4:30, Monday thru Friday.
The HIM department contracts with Ciox Health

This message is intended for use only by the individual to whom it is addressed and may contain confidential patient and/or privileged information. If you are not the intended recipient, please take note that any dissemination, distribution or copying is not permitted. If you have received this communication in error, please notify us immediately by telephone (419) 383-4982 so that we might prevent any recurrence and return faxed material by U.S. Postal Service.

Thank you for your assistance

☐ No objection to release to patient/parent ☐ DO NOT release to patient/parent

Physician Signature _____ Date _____ Time _____

Print Name _____